STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING _____ B. WING _____	C 06/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CENTER	**1201 DALY DR NEW HAVEN, IN 46774**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00130015 and Complaint IN00130137. Complaint IN00130015-Substantiated. No deficiencies related to the allegations were cited. Complaint IN00130137-Substantiated. No deficiencies related to the allegations were cited. Survey Dates: June 21 & 24, 2013 Facility number: 000114 Provider number: 155207 AIM number: 100266640 Survey team: Angela Strass, RN Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 13 Medicaid: 55 Other: 20 Total: 88 Sample: 4 New Haven Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00130015 and Complaint IN00130137. Quality Review 06/25/13 by Lisa McColly	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE